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S 000	Initial Comments Annual Licensure Survey Second Probationary Licensure Survey	S 000		
S9999	Final Observations STATMENT OF LICENSURE VIOLATIONS: 300.1210b) 300.1210d)6) 300.1220b)2)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on interview and record review the facility failed to properly assess and evaluate for potential elopement (leaving the building unnoticed) and provide supervision for one of two residents (R5) reviewed for supervision in the sample of seven. R5 was found by local police two blocks away from the facility.	S9999		

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Findings include:
According to R5's 8-7-15 Minimum Data Set (MDS) R5 has diagnoses of Dementia, Anxiety, Depression, HTN (Hypertension), and CHF (Congestive Heart Failure). R5's Social History {page 3 of 3} elopement risk question dated 1/22/15 documents, "Elopement risk ? ... could be due to dx (diagnosis)."

R5's MDS's dated 2/2/15 and 8/7/15 both document R5's BIMS (Brief Interview for Mental Status) score of 3 which is severely impaired. On R5's MDS dated 2/2/15, wandering is documented.

R5's Physician's Orders sheet for both June and July 2015 document an order for an elopement bracelet.

Nurse's Notes dated 1/22/15 at 2:20pm document R5 is "very forgetful" and that an elopement bracelet was applied. Nurses Notes on 1/22/15 at 6:30pm document R5 was found scraping the floor with a knife trying to get out of the floor.

Nurse's Notes dated 1/23/15 at 8:30pm documents R5 was up wandering in the building and 1/24/15 at 12:00pm documents R5 wants to go home.

Nurse's Notes dated 1/25/15 at 9:20pm document R5 wandered around the facility most of the shift with confusion. On 1/27/15 at 1:00pm per Nurse's Note R5 "walks per self in hallway, confused and frequently has to reorient.." There are Nurse's Notes documenting R5 "roams hallway."

Social Progress Notes dated 1/22/15 by E9 document R5 "requires cues/supervision in decision making due to dx (diagnosis). Res

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(resident) {R5} is friendly but confused and walks around the facility."

R5's Social Services Quarterly assessment dated 4/30/15 documents, "{electronic monitoring device} off and a BIMS Score: 3." R5's Social Service Quarterly assessment dates 1/22/15, 4/30/15 and 7/28/15 document memory impairment and decision making impaired.

On 5/2/15 Social Progress Notes by E9 document, "SSD (social services director) had 1:1 (one to one conversation) with res {R5}... doesn't require {electronic monitoring device} at this time."

R5's Resident Care Plan dated 7/28/15 documents {electronic monitoring device}. Notes written on the care plan include "{Electronic monitoring device} was d/c (discontinued) 5/1/15 " with a line through it as though it was discontinued on this same document.

R5's Elopement Risk Assessments dated 4/29/15, 5/1/15 and 7/24/15 document R5's total score for elopement risk as 10. The instructions on the assessment document, "... assess the resident status... If the total score is 10 or greater, the resident should be considered an elopement risk. Prevention protocols should be followed and documents on the care plan."

Nurse's Notes dated 6/9/15 at 12:15pm document, E8, Licensed Practical Nurse (LPN) "was looking for res (resident) {R5} at 11:15am to give noon pill...{R5} had been sitting out in shade...{R5} was no where to be found, staff went looking for {R5}. At 11:30am rec'd (received) call from BPD (local police department) asking if we had a res out. I {E8} stated we had staff looking

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for {R5}... {R5} noted to be approx 2 blocks from facility. Van driver {E12} called and he went and p/u (picked up) {R5}. {R5} returned to facility at 11:40am...{R5} just states, "my mind doesn't work like it used to." E8 stated at this time that R5 was returned to the facility uninjured.

E2 stated on 9-9-15 at 3:30 p.m. that there was no documentation of the facility investigation of R5's incident.

Social Services Quarterly assessment dated 7/8/15 documents, "Had to put {elopement bracelet} on due to {R5} going outside and wanting to walk but got turned around of where she was, this was 6/9/15."

On 9/9/15 at 9:15am, E8, Licensed Practical Nurse stated R5 has only left the facility grounds once. E8 stated R5 did not have a (electronic monitoring device) on at that time she left the facility because she had not been having exit seeking behaviors for about three months. E8 stated she had been looking for R5 to give her medication. E8 stated, "I actually got a call from the police." E8 stated she called E12, Van Driver to pick R5 up from where the police had her. E8 stated she was unsure of where or how R5 exited the facility.

On 9/9/15 at 9:40am, E12, Van Driver stated R5 was "about a block and a half away" when he went to pick her up. E12 stated "{R5} found someone sitting outside and they called the police who called the facility.. then the facility called me."

On 9/9/15 at 10:50am, E11, Licensed Practical Nurse (LPN) stated R5 was okay for awhile until her roommate left. E11 also stated, "I wouldn't expect {R5} to be able to sit outside by herself."

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On 9/9/15 at 3:30pm, E2, Director of Nursing (DON) stated R5 always sat outside because R5 was not an elopement risk and did not wander toward doors. E2 does not rememeber when she was notified of R5 leaving the facility and stated would "like to be notified" if a resident leaves the facility. E2 also stated, "If we feel they (residents with electronic monitoring devices) are safe we will take it (electronic monitoring device) off." E2 stated R5's electronic monitoring device was removed on 5/1/15. E2 also stated, "Maybe that was a bad judgement call; I did not make that call, it was {E8} LPN who made that call."

On 9/9/15 at 10:25am, E10, LPN MDS Coordinator stated she E10 was not familiar with R5's elopement on 6/9/15. E10 stated she had heard they (staff) put R5's electronic monitoring device back on due to R5 having an elopement." E10 stated an Elopement Assessment should be done on admission, every 90 days, when there is an elopement and when a resident "goes on or comes off" of an electronic monitoring device. E10 stated other assessments are not taken into consideration when determining elopement risk. E10 stated, "{R5} would not have been one I would have taken off the electronic monitoring device... she is very independent and can go but has memory issues... Ultimately it is E2's decision to take a resident off of an elopement risk."

On 9/10/15 at 11:00am, E8, LPN stated R5 was, "probably out on patio" where the fish pond is. E8 stated that is where R5 had sat before so E8 assumed that is where R5 had been prior to R5 leaving facility grounds. E8 was unsure of who saw R5 last on 6/9/15 because she was "going out whenever she {R5} wanted." E8 also stated R5 "has no major decision making capabilities.

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S9999	Continued From page 6 {R5} can... make simple decisions.." R5's Behavior Intervention Monthly Flow Record dated 6/2015 documents depression and pacing for R5's behaviors and is incomplete. R5's Behavior Intervention Monthly Flow Record dated 7/2015 documents crying and pacing as R5's behaviors and is incomplete. R5's Behavior Tracking Sheets dated July 2015-September 2015 are incomplete. R5's Care Plan dated revised 2/2/15 documents, "{R5} is at risk for elopement per facility assessment tool... Document all issues... If attempts to leave calmly approach and walk with resident/redirect back to unit... If elopement occurs notify administrator, DON (Director of Nursing) and proceed per their instructions. Make sure door alarms are on and working properly daily. Provide safe environment for wandering..." On 9/4/15 at 1:50pm, E2, Director of Nursing (DON) stated the facility does not have a guiding operating policy on missing residents or elopement. (A) ********** 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2)7) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy	S9999		

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S9999	Continued From page 7 Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional	S9999		

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status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
7) Coordinating the care and services provided to residents in the nursing facility.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on interview and record review the facility failed to assess and evaluate R3's unsafe smoking practices. The facility also failed to develop and implement targeted interventions to address these unsafe practices to prevent a potential fire emergency. R3 had several documented occurances of falling asleep while smoking. R3 is one of two residents reviewed for supervision in the sample of seven.

The Facility's Smoking Policy dated 8/12 documents, "The Social Service Designee will complete the smoking assessment upon admission. This assessment will focus on the resident's ability to smoke safely. Residents may be designated as Independent Smokers or Dependent Smokers who require supervision. The smoking assessment will be updated when there are significant changes in the resident's functional status or if there is a documented incident of unsafe smoking."

R3's Smoking Assessment dated 3/9/15 documents R3 is an independent smoker and R3's smoking status is unsupervised. R3's care plan dated 3/24/15 documents, "(R3) is a independent smoker."

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Nurse's Note dated 6/19/15 at 5:00 PM documents, "... (R3) had been noted sleeping in (wheelchair) out on patio (and) awoken twice by staff members (due to) sleeping (with) lit cigarette..."

Nurse's Note dated 6/21/15 at 12:54 AM documents, "... (R3) has been observed seated in w/c (wheelchair), slouched forward with lit cigarette in mouth, head down and snoring. In fact, resident's brown fleece has a ventral cigarette burn..."

On 9/10/15 at 1:10 PM, E8 Licensed Practical Nurse (LPN) stated, "(R3) will sit outside on patio smoking and will fall asleep." E8 stated, "it happened a lot more in the past but it is still happening...about a week ago (R3) was over by the pop machine and (R3) would take a drag off of cigarette and fall asleep...(R3) is an independent smoker and will go outside by (R3's) self...staff will see (R3) when they are coming back in from breaks...I would report unsafe smoking to the Social Service Director or to the Director of Nursing but everybody knows about it... everyone has seen (R3) nodding off while smoking."

On 9/9/15 at 3:10 PM, E9 Social Service Director stated "(R3) is an independent smoker...no one has ever said anything about R3 having unsafe smoking practices...if a resident is an independent smoker then no staff member is present but usually other residents will tell on them if unsafe smoking practices are seen...if I was told about (R3's) unsafe smoking practices then I would put someone with (R3) to supervise (R3's) smoking...if (R3) is burning clothes and falling asleep then (R3) should be a dependent

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S9999	Continued From page 10 smoker." On 9/10/15 at 3:30 PM, E9 stated, "(R3) has not been reassessed regarding independent smoking status. E9 stated, "if (R3) was falling asleep while smoking or burning holes in clothes then (R3) should be supervised... staff doesn't always have time to supervise smoking though." (A) ********** ********** Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) (Source: Amended at 15 Ill. Reg. 554, effective	S9999		

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S9999	Continued From page 11 January 1, 1991) These requirements are not met as evidenced by: Based on interview and record review, the facility failed to immediately report a physical altercation/possible abuse allegation between two residents to the administrator and Department and properly evaluate, remove, and monitor the perpetrator for two of three residents (R5 and R8) reviewed for abuse in the sample of seven, and two residents (R11,R12) in the supplemental sample. Findings include: 1. R5 has a diagnosis of Dementia, Anxiety and Depression documented on R5's Minimum Data Set (MDS) dated 8/7/15. R5's MDS dated 2/2/15 and 8/7/15 both document a BIMS (Brief Interview for Mental Status) of 3 (severe cognitive impairment). The Final Report of Abuse Allegation from the alleged incident on 9/4/15 between R5 and R12 dated 9/9/15 documents R12's diagnoses of Diabetes, Hypothyroidism, Coronary Atherosclerosis, Anxiety, Depression, Hyperlipidemia and HTN (Hypertension). There are no dementia or psychiatric diagnoses noted on this report for R12. R12's MDS dated 6/25/15 documents a BIMS of 13 (no cognitive impairment). The facilities Risk Indicators for Abuse and Aggressive Behavior for R5 documents an assessment on 7/28/15. There are no further assessments after the incidents had occurred on 9/4/15 and 9/7/15. The Initial Incident or Accident Form dated 9/4/15 at 1:15pm documents R12 as the resident and R5 as the "accused perpetrator." R12 accused her {R12's} new roommate {R5} of slapping her {R12's} arm. This form does not document that the incident was reported to Bloomington Police Department or the Administrator.	S9999		

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The interview document dated 9/4/15 at 1:00pm, R12 notified E8, Licensed Practical Nurse (LPN) that R5, R12's roommate, had hit her. E8 stated she asked R5 what was going on and let her know the roommate (R12) has made the allegation that she (R5) slapped her (R12). E8 documented, "(R5) looked stunned and stated, "I did not do that."... After 15 minutes, went and asked res where she {R12} was slapped and res {R12}.... glanced at r (right) arm and stated, "... she just slapped me on the arm." There is no documentation or evidence of any interventions placed to protect R12 from any further incidents while investigation was in progress. There are no Nurse's Notes documenting the altercation on 9/4/15 between R5 and R12.

On 9/9/15 at 3:25pm, R12 stated, "(R5) hit me on the right arm... I do not know why she hit me... The staff did not remove her from my room when it happened... "

R12's Behavior Tracking sheets dated May 2015 through September 2015 does not document any behaviors.

The Final Report of Abuse Allegation to the Illinois Department of Public Health regarding the incident between R5 and R12 dated 9/9/15 documents police were not notified. This report also documents, "There were no witnesses to the alleged slapping of the right arm but in conclusion the nurse {E8} felt that {R5} was sleeping soundly and did not slap anyone."

E9, Social Services Director documents room moves for R5 on 8/6/15, 9/3/15 and 9/8/15. There is not a room move documented for R5 after the alleged altercation on 9/4/15 between R5 and R12.

2. An Initial Incident or Accident Form dated 9/7/15 at 7:35pm documents a Physical altercation, between two residents. The form documents the "Accused perpetrator" as R5 and

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the other resident as R8. There were two witnesses to the incident which were R10 and R11.
On 9/9/15 at 10:05 am, R11, who witnessed the altercation stated, "(R8) got knocked down by (R5)...(R8) threatened (R5) and myself...while I was at the nurses station getting my snack, (R8) was waving her arms and said, I'm gonna knock your ass off...I took my snack and walked away but (R5) knocked her down."

On 9/9/15 at 10:45 am, R10 who witnessed the altercation stated, "(R8) is always bullying others, she is very loud and threatening, and (R5) finally had enough....(R8) and I were at the nurses station after coming in from having a smoke and (R11) was behind the nurses station fingering the snacks, (R8) told her to get her god damn ass out of there or she was going to knock her block off... (R5) was sitting in a chair at the nurses station and replied, "don't threaten my friend", (R8) then said "I'll do whatever I want, bring it on" while motioning for (R5), (R5) took off running towards (R8) reaching for her throat and knocked her to the ground."

On 9/9/15 at 11:05 am, E2 confirmed R10's story and stated, "she is alert and oriented and seen it all."

On 9/9/15 at 11:10 am when questioned what is being done to protect the safety of all the residents residing in the facility, E2 stated, "nothing...we can't tie them down, I guess we could start a discharge process but we have never had any problems with (R5) before, it is (R8) that is always bossing everyone and telling them what to do...the police were not notified because I don't think it was a malicious act...but I do think that (R8) provoked (R5)."

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R5's Nurse's Notes dated 9/7/15 at 7:35pm by E2, Director of Nursing (DON) documents, "...{R5} had a physical altercation with another resident {R8}. According to witness statements another resident {R8} was threatening another resident {R11}... {R5} stood up from chair and ran towards the resident {R8}, who was threatening, and Grabbed this resident {R8} around the neck area and knocked her down on her back et (and) was on top of her..."

R5's Behavior Tracking and Special Behavior symptom Evaluation Program documents are incomplete for July 2015, August 2015 and September 2015. There is no documentation on these same documents regarding the incidents that occurred on 9/4/15 and 9/7/15.

On 9/8/15 at 1:30pm, R5 was standing in the hall talking on the phone and stated, "... you gotta run for your life around here... I've had it by too damn many people here..."

R5 went to an appointment on 9/9/15 at 10:30am that R5 had made with Z1, Medical Doctor (MD). Z1's Physician's Progress Notes dated 9/9/15 documents, "Resident altercation with a demented resident {R5} with injury to R (right) ribs. R rib contusion... case discussed with DON (Director of Nursing) of NH (nursing home) to ensure usual protocol to protect residents initiated." There was a chest X-ray done at that visit with results that document, "...Kyphosis and a fracture of the mid thoracic vertebra are seen."

On 9/10/15 at 2:45pm, Z1, MD, stated the age of the fracture of the vertebra was unknown and R8 was not tender in that area. Z1 stated the X-ray did not show if the fracture was old or new and could not determine that the incident caused the fracture but that R5 does have a right rib contusion.

3. R8's Nurse's Notes dated 7/29/15 at 9:00am documents, "{R8} was in a verbal and physical

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S9999	Continued From page 15 altercation with another resident {R11}...{R11} hit {R8} with a closed fist in R (right) shoulder et (and) threatened {R8} with a fork... told her to stay away from {R11}. On 9/10/15, E2, Director of Nursing (DON) stated on 7/29/15 at 11:35am, R8 was trying to get coffee when R11 hit R8. E2 stated this incident "was not reported to Public Health." There is no evidence of interventions placed for safety or that any residents were monitored after the incident. The Facilities undated "Abuse Prevention Policy" documents, "To prevent abuse... it is the policy of ASTA Care Center of Bloomington to... 5. Protect Residents: An individual alleged to abuse... a resident will be removed from the facility to protect the residents... A resident who abuses another resident will also be reported to IDPH... 6. Internal Report and Initial Investigation: All abuse allegations and reasonable suspicions of a crime against a resident must be reported to the charge nurse, DON (Director of Nursing) or administrator immediately. ASTA Care Center of Bloomington must give IDPH an initial report immediately. The administrator will actively investigate allegations of abuse as well as all resident incidents... 7. External Report: The administrator and/or... must report it to the police and the Illinois Department of Public Health..." (B) ********** ********** 300.2100 FOOD HANDLING SANITATION Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm.Code 750). Section 750.140 b) 1 Refrigerated Storage	S9999		

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Potentially hazardous food requiring refrigeration after preparation shall be labeled or tagged with the date and time of preparation and rapidly cooled to an internal temperature of 41 F. Potentially hazardous foods of large volume or prepared in large quantities shall be rapidly cooled, utilizing such methods as limiting depth of food to 4 inches or less, agitation, quick chilling or water circulation external to the food container...Cooked potentially hazardous food shall be cooled: From 135 F to 70 F. within 2 hours ; and From 70 F to 41 F, or below within 4 more hours (or within a total of 6 hours).

These requirements are not met as evidenced by:

Based on observation, record review and interview the facility failed to utilize methods of quick cooling of hot potentially hazardous food and failed to monitor the cooling temperatures of turkey roast and beef roast to ensure a safe internal temperature of 41 degrees F (Fahrenheit) or below was obtained within 6 hours to prevent bacterial growth, that if consumed, could result in resident food borne illness. This has the potential to affect all 88 residents residing in the facility.

Findings include:

1. On 9/8/15 at 9:15 am two large steam table pans, each containing two large turkey roasts were stored in the refrigerator in the Dietary Department. Each turkey roast weighed approximately 10-12 pounds per interview with Cook E4, at that time. The steam table pans were covered with aluminum foil that was vented on one corner. The roast were whole and had broth that was approximately 6 inches deep had not been poured off. The label on the roasts was dated 9/07/15. There was no time or

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temperatures recorded. The internal temperature of the roast measured between 48-52 degrees F. Registered Dietician (RD) E3, who is the Dietary Manager stated at that time, the turkey roasts were cooked on 9/7/15 by the evening staff. E3 stated she would expect the meat to be cut in half, removed from the broth and be in shallow pans to cool quickly instead of being left in the broth whole. At 9:20 am, E4 checked the temperature of the turkey with a facility thermometer and stated the temperature was 39 degrees F. An ice point calibration field test was conducted on the facility thermometer. After the thermometer was calibrated, E4's thermometer registered 50 F. when placed in the turkey roast.

On 9/8/15 at 9:25 am E3 was asked to provide the cooling log or any temperature monitoring documentation. E3 did not know if the facility had a cooling log as E3 has only worked as the Dietary Manager for two weeks. Cook E4 stated, at this time they currently do not have cooling logs. E3 and E4 confirmed they worked in the kitchen on 9/7/15 but had not done any temperature monitoring of the turkey roasts. E4 stated the turkey was still in the oven when E4 had left for the day on 9/7/15.

An undated policy entitled "Rapid Cooling of Food" was hanging on a refrigerator in the kitchen on 9/8/15 at 9:30 am. The policy/procedure stated: "Cool potentially hazardous foods from 135 F. to 41 F. within 6 hours. Purpose: To reduce the risk of food borne illness. Procedure 1. Separate food into small batches prior to refrigeration. 2. Limit the depth of the pan used for cooling to approximately 2 inches...4. Lightly cover food. Do not securely wrap containers during the cooling process as this will trap heat and lengthen the time to chill foods. 5. Food may

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be placed in an ice bath or in the freezer to decrease cooling time. There should be a barrier between the food and the ice..6. Rapidly cool food from 135 F to 70 F. in two hours. Continue cooling food from 70 F. to 41 F. in the final 4 hours of cooling. If the food item is not chilled from 135 F. to 70 F. in 2 hours the food must be quick chilled to 41 F. in 2 hours. 7. Monitor temperature on appropriate form." E3 confirmed at that time that this was the facility's current policy for cooling.

The menu for 9/8/15 planned for Open Faced Hot Turkey Sandwiches to be served to residents at supper. E3 confirmed on 9/08/15 at 9:30 am that the turkey would have been served to residents that night. E3 stated at that time they would need to prepare a substitute. E3 removed the improperly cooled turkey from potential service to residents on 9-8-15 at 9:30 a.m. E3 voluntarily discarded the 48 pounds of improperly cooled turkey roast.

On 9/09/15 at 10:20 am Evening Cook E6 confirmed she had cooked the turkey roasts on 9/7/15. E6 stated the roasts cooked from 11:30 am until approximately 5:00 pm and the temperature of the turkey was 189 F. when removed from the oven. E6 stated the turkey was allowed to cool to room temperature on the stove top. E6 placed the roast in the refrigerator approximately 7:30 pm and left for the night. E6 stated at that time she was aware she was supposed to cut the meat up and pour off the broth before putting in the refrigerator but E6 did not do that. E6 stated she did not take any other temperatures to monitor the cooling of the turkey that night. E6 stated she was not aware of the time/temperature requirements for cooling meat. E6 stated, "We were never told to take the

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S9999	Continued From page 19 temperature every two hours." On 9/9/15 at 10:30 am E3 stated that E6 has not completed a food service sanitation course. 2. On 9/8/15 at 9:15 am Cook E5 stated a roast beef was in the oven cooking. E5 indicated the roast would be served on 9/09/15 for lunch. On 9/08/15 at 12:10 pm Cook E4 checked the temperature of three beef roasts and stated it was 160 degrees F. E4 put the meat back into the oven stating they were going to cook the roast to 180 degrees F. On 9/8/15 at 4:20 pm one steam table pan full of cut up roast beef in broth was stored in the refrigerator. The pan was covered with foil and was vented on one corner. The label was dated 9/08/15. There was no time or temperatures recorded. The internal temperature of the roast measured 99 degrees F. E3 stated at that time the roast was 185 degrees F when removed from the oven around 1:00 pm. E3 stated at that time, that Cook E5 had prepared the roast and had left for the day at 1:30 pm. E3 stated she could not find a cooling log. E3 stated at 4:40 pm, that no one has been monitoring the cooling of the beef roast. E3 felt there was still time to get the temperature down to 41 or below before the 6 hour window was up and stated E3 would put the meat in shallow pans with ice and would monitor the temperature. On 9/9/15 at 9:20 am Cook E5 confirmed that she had taken the beef roast out of the oven at 1:00 pm and the temperature was 189 F. E5 stated she did not write down the temperature of the meat. E5 stated she poured the broth off the meat and dumped 2 gallons of ice over the meat and placed it in the refrigerator right before	S9999		

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leaving for the day at 1:30 pm. E5 stated she thought E3 or E4 would monitor the rest of the cooling.

On 9/9/15 at 9:30 am E3 confirmed that a cooling log was put in place on (9/08/15) after 4:30 pm and E3 was able to get the temperature of the beef roast down to 40 F. before the six hours was over. E3 confirmed that E5 had not communicated to her that the roast beef needed monitoring before leaving on 9/8/15. E3 stated on 9/9/15 at 10:00 am she had not had an inservice for the staff yet on how to properly cool food. E3 stated the last inservice she could find that addressed proper cooling of foods and preventing food borne illness was conducted with dietary staff on 5/20/15. The inservice attendee sign in sheet dated 5/20/15 documented E5 attended the inservice. E6's name was not on the list of attendees.

The inservice dated 5/20/15, "Food Borne Illness" documented areas that are critical in preventing food borne illness which included "Time/Temperature" monitoring. The Food Borne Illness Test Answer Guide stated "Describe rapid cooling." Answer: "Cooling a cooked product quickly 140 degrees F. -70 degrees F. in 2 hours, 70 F. - 41 F in 4 hours. Question: " What is the Danger Zone?" Answer: "41 F-140 F."

E3 stated on 9/9/15 at 4:00 pm "I wasn't aware the staff weren't doing cooling monitoring. They need to communicate to each other when something needs monitored between shifts".

The facility Resident Census list dated 9/08/15 documents a census of 88 residents.

(B)

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S9999	Continued From page 21 ********** **********300. 3130 c)4) Plumbing Systems Hot water available to residents at shower, bathing and hand washing facilities shall not exceed 110 degrees Fahrenheit. This requirement is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that hot water did not exceed 110 degrees F. (Fahrenheit) and pose a potential burn hazard to residents. Excessively hot water at hand washing sinks was available to residents on the 300 wing of the facility. This had the potential to affect eight residents on the supplemental sample (R22-R29). Findings include: On 9/10/15 at 10:15 am, the door to the 300 wing shower room was open. The room contained a hand washing sink, shower and whirlpool bathtub. The hot water at the hand washing sink measured 119 degrees F and was very hot to the touch. Housekeeping Supervisor E20, who was present at that time, confirmed the thermometer was reading 119 degrees F and the water felt very hot. On 9/10/15 at 10:30 am, the hot water at the hand washing sink shared by R27 and R28 measured 130 degrees F. The hot water temperature initially started out cool, but the temperature kept climbing until it stabilized at 130 degrees F. E20 confirmed, at that time, that the water was excessively hot.	S9999		

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On 9/10/15 at 10:35 am, the hot water at the hand washing sink adjacent to the 300 wing Dining Room measured 130 degrees F. Activity Staff E18 witnessed the temperature on the thermometer and felt the hot metal of the faucet and confirmed the water was "way too hot." E18 stated that this bathroom is connected to R24's room. E18 stated R24 uses the bathroom independently.

On 9/10/15 at 10:40 am Maintenance Director E7 was informed that the hot water was excessively hot on the 300 Wing.

On 9/10/15 at 10:45 am the hot water at the hand washing sink in R22's and R23's room measured 120 degrees F. E7 witnessed the temperature reading on the thermometer and stated that the hot water heater should be set at 112 degrees F, and the hot water should not exceed 110 degrees at the sinks. E7 then checked the gauges of the mixing valve located in a recessed access panel near R22's room. The outgoing water temperature gauge was registering 125 degrees F. The incoming water temperature gauge was full of water and was unreadable. E7 stated that no one had reported any excessive hot water temperatures to him. R22 was asleep in the bed during the observation. R22 was observed independently ambulating in the hallways on 9/10/15 at 11:00 am.

On 9/10/15 at 11:00 am E7 reported that the mixing valve for the 300 wing hot water was stuck and needed to be cleaned out. E7 stated at 11:45 am there was a lot of calcium build up and a rubber gasket that had to be replaced. E7 stated that he checks the mixing valves once per month. Per the Maintenance Plant Daily Round logs the

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mixing valve was last checked on 8/7/15. E7 clarified he tests the hot water at random resident rooms on each wing on a daily basis during the week.

Water logs reviewed from 8/28/15-9/9/15 document one room on the 300 wing checked was checked daily Monday through Friday with recorded temperatures between 109-110 degrees F.

On 9/10/15 at 1:10 pm Certified Nurse Aide (CNA) E17 identified the cognitively impaired residents that were ambulatory and could potentially gain access to the hot water at hand washing sinks as R22, R23, R24, R25, R26, R27, R28, and R29.

(B)

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Section 300.696 Infection Control
c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):
2) Guideline for Hand Hygiene in Health-Care Settings
6) Guideline for Isolation Precautions in Hospitals
7) Guidelines for Infection Control in Health Care Personnel
(Source: Added at 29 Ill. Reg. 12852, effective August 2, 2005)
These requirements are not met as evidenced by:
Based on observation, interview and record

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review the facility failed to complete hand washing with soap and water for a resident with Clostridium Difficile (CDiff) and failed to decontaminate resident care equipment for two of three residents (R4 and R6) reviewed for infection control in the sample of seven residents. This failure has the potential to affect four residents (R1, R3, R4 and R6) in the sample of seven residents and eight residents (R10, R12, R13, R16, R18-R21) in the supplemental sample. Findings include:

1. R4's Laboratory Report dated 9/2/15 documents results of "C. difficile Toxins A+B" as "Positive." R4 was placed in contact isolation upon notification of the results of the stool test on 9/2/15.

On 9/8/15 at 11:15am, E8, Licensed Practical Nurse (LPN) applied a gown and gloves, entered R4's room and checked R4's blood glucose with the glucose monitor machine. E8 completed the test, removed her gown and gloves and then left the room without washing her hands with soap and water and without disinfecting the glucose monitor machine. E8 touched the medication cart and used hand sanitizer on her hands. E8 proceeded to open the drawer of the medication cart and pulled out a chlorine bleach wipe and wiped the glucose monitor machine and placed it directly on the cart. The glucose monitor machine was only wet for two to three seconds before E8 placed the glucose monitor machine on top of the cart potentially contaminating the area where the machine was placed on the cart.

R4's Care Plan for Contact Isolation for Clostridium difficile dated 9/4/15 documents to, "Disinfect all equipment before it leaves the room."

On 9/9/15 at 3:35pm, E23, Certified Nursing Assistant (CNA) stated R4 does have episodes of incontinence but is usually independent and lets

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staff know when he {R4} needs help. E23 stated, "I have to disinfect after (R4) uses the toilet... in order to clean properly they use the chlorine bleach wipes and wipe from top of tank down to sink or bowl, give it 30 to 45 seconds sometimes a minute then I try and wipe the chemical back off... this cleaning is done after each time (R4) tells staff he used the toilet...(R14) uses the same toilet as (R4)."
On 9/14/15, E2, Director of Nursing (DON) supplied a list of residents (R1, R4, R10, R12, R16, R18-R21) who "use the 100/400" Hall glucose monitoring machine.
2. R6's Care Plan dated 8/24/15 documents R6 has an indwelling catheter. R6's laboratory report dated 9/3/15 documents R6's urine culture grew greater than 100,000 colonies of Extended Spectrum Beta-Lactamase (ESBL) organisms. Nurse's Note dated 9/6/15 documents R6 is in isolation for urinary infection with ESBL.
On 9/8/15 at 1:35 PM, E13 Certified Nurse's Assistant (CNA) and E14 CNA provided catheter care to R6. E13 took a washcloth from a wash basin filled with soapy water and washed R6's catheter tubing. E13 then washed R6's perineal area using a different washcloth for each swipe. E13 did not change gloves between taking washcloths from the wash basin. After providing cares to R6, E13 took the wash basin which contained contaminated water and empted it into the sink in the bathroom. E13 did not sanitize the sink after emptying the wash basin.

On 9/8/15 at 1:50 PM, E13 stated,"I should have wiped the sink down after emptying wash basin." E13 stated R6 shares a bathroom with R3. E13 stated that R3 uses the sink in the bathroom.

On 9/8/15 at 2:25 PM, E2 Director of Nursing stated, "(E13) should not have dumped

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S9999	Continued From page 26 contaminated water into sink." 3. R6's Care Plan dated 8/24/15 documents R6 has an indwelling catheter. R6's laboratory report dated 9/3/15 documents R6's urine culture grew greater than 100,000 colonies of Extended Spectrum Beta-Lactamase (ESBL) organisms. Nurse's Note dated 9/6/15 documents R6 is in isolation for urinary infection with ESBL. On 9/8/15 at 1:50 PM, E13 stated, "(R6) is using (R13's) geriatric chair because (R6's) wheelchair was too wide to get onto the van and (R6) was going to an appointment, (R13) was using (R6's) wheelchair until return from the appointment." On 9/8/15 at 2:00 PM, R13 was lying in bed. A wheelchair was parked beside R13's bed. A catheter bag cover was tied to the left arm rest of the wheel chair. At that time, E13 stated that the wheelchair belonged to R6 and that the catheter bag cover was left on the wheelchair. E13 stated that the catheter bag cover should have been taken off R6's wheelchair prior to taking it out of R6's room. On 9/14/15 at 10:10am, E2, Director of Nursing (DON) provided the chlorine bleach wipes "Directions For Use" dated 2012. Directions include, "1... When disinfecting C. Difficile spores, always clean surfaces prior to disinfecting. 2. Wipe surface with towel until completely wet... 3. To Disinfect, allow surface to remain wet for one minute... To kill C. difficile spores, allow 5 minutes contact..." The facilities policy for Contact Precautions dated 12/1/14 documents to, "4. Use Standard Precautions for the care of all residents... 7. Placing Residents in Contact Isolation: Residents will be placed in Contact Isolation and use Contact Precautions when... based on a review of the resident's clinical symptoms and/or culture and sensitivity reports."	S9999		

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The facilities policy for Standard Precautions dated 12/1/14 documents, "1. Use Standard Precautions for the care of all residents... 5. When to Wash Hands:... c. After removing gloves or other personal protective equipment... 9... d. Wash hands as soon as possible after glove removal... 13. Equipment: ... b. Make sure reusable equipment is not used for the care of another resident until it has been cleaned appropriately... 18. Isolation: a. Follow contact.... (see protocols) depending on the needs of the affected residents..."

(B)

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Section 300.1020 Communicable Disease Policies
a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
b) A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part. In determining whether a transfer or discharge is necessary, the burden of proof rests on the facility.
(Source: Amended at 29 Ill. Reg. 12852, effective August 2, 2005)
These requirements are not met as evidenced by:
Based on interview and record review the facility failed to place one resident (R4) on isolation due to presence of symptoms and while waiting for

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results of the stool culture due to a possible Clostridium difficile (Cdiff) infection. R4 was one of three residents reviewed for infections in the sample of seven
Findings include:
The facility's policy for Contact Precautions dated 12/1/14 documents to, "4. Use Standard Precautions for the care of all residents... 7. Placing Residents in Contact Isolation: Residents will be placed in Contact Isolation and use Contact Precautions when... based on a review of the resident's clinical symptoms and/or culture and sensitivity reports."
R4's Daily Skilled Nurse's Note dated 8/20/15 documents, "... BM's (bowel movements) with foul smell." The Daily Skilled Nurse's Note dated 8/29/15 documents diarrhea on day shift. The Daily Skilled Nurse's Notes dated 8/30/15 and 8/31/15 document foul odor to stool.
R4's facsimile cover sheet dated 8/31/15 to R4's physician documents, "Can we check a stool for CDiff..... Foul smelling stools." The Physician's Orders Sheet dated 8/31/15 documents, "stool culture to R/O (rule out) C-diff."
R4's Laboratory Report dated 9/2/15 documents results of Clostridium difficile Toxins A+B as "Positive."
On 9/9/15 at 9:05am, E8, Licensed Practical Nurse (LPN) stated R4 was not placed in isolation until the positive Clostridium difficile result was received on 9/1/15.
The positive lab test report documents the positive Clostridium difficile result as reported 9/2/15. R4's Daily Skilled Nurse's Note dated 9/2/15 documents R4 was "+ (positive)" for Clostridium difficile. "Put in isolation..."
On 9/9/15 at 9:10am, E16, Registered Nurse (RN) stated R4's stools had a foul smell and "looked weird." E16 also stated she notified E2, the Director of Nursing and they checked it the

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S9999	Continued From page 29 Monday after the weekend that it looked "weird" and that R4 was not in isolation at that time. (B) ********** Section 300.1650 Control of Medications a) The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications. (Source: Amended at 27 Ill. Reg. 5862, effective April 01, 2003) These requirements are not met as evidenced by: Based on observation, record review, and interview, the facility failed to properly dispose of a Schedule II Controlled Substance for one resident R16 in the supplemental sample. Findings include: On 9/8/15 at 11:00am, an item that resembled a medication patch was in the sharps container on top of the door and was stuck to the door of the sharps container. On 9/8/15 at 11:08am, E8, Licensed Practical Nurse (LPN) had left the cart. The patch remained in the same location upon E8's return to the cart. At 11:10am, E8 left the cart in the hall to go get supplies for an isolation room. At 11:11, R17, who E8 stated has confusion, was walking in the hall with her walker and around the cart and back and forth between two rooms. At 11:13am when E8, LPN was questioned about the possible patch in the sharps container, E8 stated, "Oh yeah, that looks like a Fentanyl (narcotic) Patch ." E8 proceeded to pull the patch out of the sharps container as it was reachable. The item was labeled a Fentanyl Patch 75mcg (micrograms) and dated 9/4/15. E8 stated this Fentanyl Patch belonged to R16. E8 stated the Fentanyl Patch would have been disposed of in the sharps	S9999		

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container on the cart on the evening of 9/7/15 as that is the date the new one was placed. E8 stated it must have gotten stuck because it was not in tissue and they usually dispose of the Fentanyl Patch by placing in tissue and placing in the sharps container. R16's Used Fentanyl Patch Disposal form dated September 2015 documents disposal of a Fentanyl Patch 75mcg on 9/7/15. The facility's Policy and Procedure for Proper Disposal of Used Fentanyl Patches dated 5/20/15 documents, "... Fold in half and dispose of in sharps container with another nurse as witness... Any concerns should be addressed to DON (Director of Nursing)."

(C)

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Section 300.1210 General Requirements for Nursing and Personal Care
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
(Source: Amended at 35 Ill. Reg. 11419, effective June 29, 2011)
These requirements are not met as evidenced by:
Based on observation and record review, the facility failed to properly administer two medications for one of four residents (R15) reviewed for medication administration pass opportunities with two errors resulting in an error rate of 6.66%. R15 is one resident on the supplemental sample.
Findings include:
On 9/9/15 at 4:25pm, E22, Licensed Practical

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Nurse (LPN), administered R15's medications. R15 took the Atrovent HFA (Hydrofluoroalkane) inhaler and placed the mouth piece in his mouth, sprayed the inhaler in to the mouth and then inhaled one puff. R15 inhaled a second puff about 10 seconds later. R15 did not breathe out before inhaling the medication and did not take a deep breath to inhale either puff. E22, LPN did not instruct R15 on how to use the inhaler. R15 then proceeded to take the Ventolin HFA inhaler, place the mouth piece in the mouth and inhaled 2 puffs with 5 seconds in between each puff. R15 did not breathe out or take a deep breath during the inhalation of the Ventolin HFA inhaler. R15 did not shake the Ventolin HFA inhaler between puffs. During inhalation of both the Atrovent HFA and Ventolin HFA inhalers, R15 sprayed the inhaler in to R15's mouth before inhaling the medication.
On 9/9/15 at 4:26pm E22 stated R15 only waited about 10 seconds between the puffs of the Atrovent HFA inhaler and about five seconds between each puff of the Ventolin HFA inhaler. E22 also stated there was 30 seconds between the Atrovent HFA administration and the Ventolin HFA administration.
The undated Instructions For Use for Atrovent HFA Inhalation Aerosol documents, "... 3. Breathe out (exhale) deeply through your mouth... 4. Breathe in (inhale) slowly through your mouth and at the same time spray the Atrovent HFA into your mouth... Keep breathing in deeply. 5. Hold your breath for 10 seconds and then take the mouthpiece out of your mouth... 6. Wait at least 15 seconds and repeat..."
The undated Instructions for Use for the Ventolin HFA inhaler documents, "Follow these steps every time you use your Ventolin HFA... Step 3. Breathe out through your mouth and push as much air out from your lungs as you can... Step 4. Push the top of the canister... while you breathe

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S9999	Continued From page 32 in deeply and slowly through your mouth... Step 5. After the spray comes out... After you have breathed in all the way take the inhaler out of your mouth... Step 6. Hold your breath for about 10 seconds... Breathe out slowly as long as you can. If your healthcare provider has told you to use more sprays, wait 1 minute and shake the inhaler again. Repeat Steps... For correct use of your Ventolin HFA inhaler, remember... Breathe in deeply and slowly to make sure you get all of the medicine. Hold your breath for about 10 seconds after breathing in the medicine..." (B) ********** ********** Section 300.1230 Direct Care Staffing b) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day. d) Each facility shall provide minimum direct care staff by: 1) Determining the amount of direct care staffing needed to meet the needs of its residents; and 2) Meeting the minimum direct care staffing ratios set forth in this Section. l) To determine the numbers of direct care personnel needed to staff any facility, the following procedures shall be used: 1) The facility shall determine the number of residents needing skilled or intermediate care. 2) The number of residents in each category shall be multiplied by the overall hours of direct care needed each day for each category. 3) Adding the hours of direct care needed for the residents in each category will give the total hours of direct care needed by all residents in the	S9999		

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facility.
4) Multiplying the total minimum hours of direct care needed by 25% will give the minimum amount of licensed nurse time that shall be provided during a 24-hour period. Multiplying the total minimum hours of direct care needed by 10% will give the minimum amount of registered nurse time that shall be provided during a 24-hour period.
5) Additional Direct Care Hours Equal to at Least 75% of the Minimum Required
The remaining 75% of the minimum required direct care hours may be fulfilled by other staff identified in subsection (f) as long as it can be documented that they provide direct care and as long as nursing care is provided in accordance with the Nurse Practice Act.
6) The amount of time determined in subsections (l)(4) and (5) is expressed in hours. Dividing the total number of hours needed by the number of hours each person works per shift (usually 7.5 or 8 hours) will give the number of persons needed to staff each shift. Calculations shall not include time for scheduled breaks or scheduled in-service training. The number of residents used to calculate staff ratios shall be based on the facility's midnight census.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to have the minimum required Direct Care Staff for 3 of 14 days reviewed. This failure has the potential to affect all 88 residents residing in the facility.

Findings include:

The undated spread sheet provided by E2, Director of Nursing, on 9/9/15 documents the

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period of time reviewed for staffing as 8/20/15 - 9/2/15. The spread sheet documents an average daily census of 5.07 Skilled residents and 85.93 Intermediate residents, which requires a minimum of 234.09 hours of direct care staff daily. The 234.09 minimum staff hours are divided up between 25% licensed staff totaling 58.52 hours per day and 75% unlicensed staff totaling 175.56 hours per day.

The spread sheet documents the following hours per day for licensed and unlicensed staff.

8/22/15 - Licensed hours 65.75 and Unlicensed hours 147 for a total of 212.75 Direct Care Staff hours
8/29/15 - Licensed hours 62.25 and Unlicensed hours 161.50 for a total of 223.75 Direct Care Staff hours
8/30/15 - Licensed hours 57.5 and Unlicensed hours 149.50 for a total of 207 Direct Care Staff hours

The scheduled date 8/20/15 - 9/2/15 confirms these hours worked by the staff.

On 9/10/15 at 10:50 am, E2 stated, "the hours are right, I am short CNA (Certified Nursing Assistant) hours, especially on the weekends, and then when they call in, it leaves us even shorter...I'm doing the best I can with what I have to work with."

(AW)

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S9999	Continued From page 35 300.3100 d)2 General Building Requirements All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. This requirement is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that the exterior doors for the 200 wing patio doors are alarmed or supervised to alert staff if a resident leaves the building. This has the potential to affect five residents (R1, R2, R3, R4, R7) in the sample of seven and 20 residents in the supplemental sample (R8, R9, R10, R11, R12, R13, R15, R17, R23, R25, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38) The findings include: On 9/9/15 at 4:00 pm the exterior door for the smoking patio at the far end of the 200 Wing was opened. There was no audible alarm heard. A group of independent resident smokers (R10, R8, R15, R25) were seated in the smoking patio. Social Service E9 stated at that time that the general door alarms are turned off during the day due to the frequent use by independent smokers. E9 stated the door does have a (electronic monitoring device) signal that will sound if a resident wearing an (electronic monitoring) bracelet opens the door. On 9/9/15 at 4:15 pm E9 brought R21,who was wearing a monitoring bracelet to the smoking patio door and the alarm sounded.	S9999		

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On 9/9/15 at 4:10 pm the door alarm panel at the nurses station had showed a green light for the courtyard patio door and the smoking patio door of the 200 wing which indicated the door alarm was turned off. The courtyard patio door is not visible from the nurses station and the smoking patio door at the far end of the wing is not visible from the nurses station. Part of the courtyard patio is visible through the therapy area window across from the nurses station. E9 stated at that time, "Someone must have forgotten to turn the door alarm back on after someone went out...there are independent residents that sit out in the courtyard." E9 pushed the button and the indicator light turned red indicating the alarm was activated. There were no residents in the courtyard at the time.

The courtyard door is at the beginning of the 200 wing and is a large fenced yard. There is an open gate with a side walk that leads to the parking lot. The smoking patio door leads to a fenced patio with a closed but unlocked gate.

On 9/10/15 at 2:00 pm the door alarm panel at the nurses station indicated the two exterior doors on the 200 wing were turned off. A group of independent smokers were outside on the smoking patio including R8 and R34 who came in and out of the smoking patio doors with no alarms sounding.

On 9/14/15 at 12:30 pm Director of Nurses E2 stated that all the exterior doors are equipped with an (electronic bracelet monitoring) system that will alarm if a resident wearing an (electronic monitoring bracelet) exits the building. E2 stated the exit doors also are equipped with a general alarm. E2 stated the general alarms for the front

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door and for the resident smoking patio are turned off during the day. E2 stated the front door alarm is turned back on after the Receptionist (E25) leaves. E2 stated "The independent resident smokers will let the staff know if a resident who shouldn't be there comes out to the patio."

E7 Maintenance Director stated on 9/14/15 at 12:40 pm he checks the function of the (electronic monitoring) alarm and the general door alarm every day to ensure function. E7 confirmed that the front door and 200 wing smoking door general alarms are on bypass during the day and reactivated on the second shift. Only residents wearing the (electronic monitoring bracelets) will set off the alarm at those doors.

Based on observations and review of the 8/28/15 list "Residents Out and About with (Electronic Monitoring Bracelets)" there are 25 residents who are at risk of elopement (leaving the building unnoticed) and do not wear monitoring bracelets, including R1, R2, R3, R4, R7, R8, R9, R10, R11, R12, R13, R15, R17, R23, R25, R29, R30, R31, R32, R33, R34, R35, R36, R37, and R38)

The undated Door Alarm Policy states:" All exit doors will be alarmed and monitored on a regular basis...To safeguard residents and staff...Security Alarms will be placed on the following doors..All facility exits...Alarms are on the following doors but not normally activated due to amount of activity though doors. a) Front Entrance Monday-Friday 7:00 am to 5:00 pm. b)Patio door 5:30 am to 8:00 pm.."

(B)

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IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Arba Care Center of Bloomington

DATE AND TYPE OF SURVEY: Annual Licensure Survey and Second Probationary Survey conducted September 14, 2015

300.1210b)

300.1210d)6)

300.1220b)2)3)

300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

This will be accomplished by:

I. All residents will be assessed to determine safety risk related to exit seeking behavior and results will be incorporated into individual care plans. If exit seeking behaviors are noted, increased security measures will be implemented until the resident no longer exhibits the behavior.

II. All policies and procedures related to the assessment and supervision of residents with exit seeking behavior will be evaluated and revised as needed to ensure compliance with Illinois Skilled Nursing and Intermediate Care Facilities Code. The facility will develop and implement a policy on actions to be taken when a resident has eloped or is missing.

III. All staff will be in-serviced on policies and procedures pertaining to the recognition, assessment and supervision of residents with exit seeking behavior; increased security measures to be implemented when a resident exhibits exit seeking behavior, appropriate actions concerning the operation and maintenance of door alarms, the action plan to be implemented when a door alarm fails, and the action plan to be implemented when a resident has eloped or is missing.

IV. Documentation of in-service training, assessments, policy and procedure review and development, and related follow up actions will be maintained by the facility.

V. The Administrator and QA committee will monitor items I through IV to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Within 10 days of receipt of this notice.

10/7/15/lo

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IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Arba Care Center of Bloomington

DATE AND TYPE OF SURVEY: Annual Licensure Survey and Second Probationary Survey conducted September 14, 2015

300.610a)

300.1210b)

300.1210d)6)

300.1220b)2)7)

300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

7) Coordinating the care and services provided to residents in the nursing facility.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
or neglect a resident.

This will be accomplished by:

I. All residents who smoke will be assessed to determine safety risk related to smoking practices and results will be incorporated into individual care plans. If unsafe smoking practices are noted, interventions to address smoking safety and fire prevention will be developed and implemented.

II. All policies and procedures related to the assessment and supervision of resident's who smoke will be evaluated and revised as needed to ensure the safety of all residents. The facility will develop and implement a policy on actions to be taken when unsafe smoking practices are observed. Each resident will be re-assessed for need of smoking supervision and resident's care plan will be updated after each and every incident of unsafe smoking practice.

III. All staff will be in-serviced on policies and procedures pertaining to the assessment and supervision of residents who smoke including measures to be implemented when a resident exhibits unsafe smoking practices.

IV. Documentation of in-service training, assessments, policy and procedure review and development, and related follow up actions will be maintained by the facility.

V. The Administrator and QA committee will monitor items I through IV to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Within 10 days of receipt of this notice.

10/7/15/lo